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INSIDE

RELIAS MEDIA

Cultivate Relationship With Board for Better Support of Quality Improvement

Quality professionals often wish for more support from the board of the hospital or health system — the kind of top-tier backing that can drive a quality improvement initiative to success.

Such support requires a good relationship with the board, and that often requires quality professionals to take the first steps.

Many hospitals require the quality improvement department to report directly to the board on a regular basis, and more are now developing quality committees for the board, notes **Jessica Turgon**, principal with ECG Management Consultants in Arlington, VA.

"We're starting to see a greater sophistication in quality reporting and key initiatives to focus on. It's not just the basics anymore when you go to the board," Turgon says. "There is more interest from the board, and that means there is pressure on the management team to demonstrate that you are providing quality care — more than just providing HEDIS [Healthcare Effectiveness Data and Information Set] scores and basic quality outcomes. They are more interested in hearing about specific performance improvement projects."

> QUALITY PROFESSIONALS CAN CULTIVATE A CLOSE AND PRODUCTIVE RELATIONSHIP WITH THE HOSPITAL BOARD BY KEEPING HEALTHCARE QUALITY AT THE FOREFRONT OF THE AGENDA.

As a result, quality improvement departments may need to bolster their infrastructure in order to track and manage data, she says.

A potential barrier is that hospital quality departments often are seen as primarily responsible for compliance

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AUTHOR: Greg Freeman

EDITOR: Jesse Saffron
(919) 377-9427 (jsaffron@relias.com)

EDITOR: Jill Drachenberg
(404) 262-5508 (jdrachenberg@relias.com)

EDITORIAL GROUP MANAGER: Terrey L. Hatcher

SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

rather than a quality improvement model, says **Scott J. Cullen**, MD, principal with ECG Management Consultants in Boston. The compliance part of quality is not all that sexy when talking to the board, so it can be harder to encourage participation, he says.

But that could be changing. With their financial interests, hospital boards have traditionally been more focused on donors and other constituencies than on competency and quality, Cullen says. Now, many hospital boards are moving more toward a competency-based governance model.

"As that shifts, I think you'll see a little less friction and more traction around system-level initiatives regarding quality," he says.

Get on the Agenda

Quality professionals can cultivate a close and productive relationship with the hospital board by keeping healthcare quality at the forefront of the board agenda, says **Tracey Klein**, JD, shareholder with the Polsinelli law and consulting firm in Chicago.

Linking education on quality and improvement to the board's fiduciary duty of oversight is critical, she says. For starters, comprehensive training on the health system's quality and improvement programs should be part of board member orientation.

"Offering to do semi-annual presentations can highlight achievements, as well as offering board members an opportunity to ask questions and learn about the clinical aspect of the enterprise. If the board does not have a quality committee, consider establishing one and moving quality to the forefront of the board agenda on a regular basis," she says. "Candor and transparency are essential to the process. Quality should be given priority on the board agenda."

When the board tracks quality and enhances its level of oversight of quality, it sets the tone from the top, Klein explains. This encourages administration to put enhanced resources behind making improvements.

Hard Topics

In the early 2000s, Klein became a frequent lecturer on quality and board governance. She sat on a health system board as legal counsel and found that board members were interested in education and further development on quality issues. *(See the sidebar on page 27 for more about Klein's experience with boards and quality.)*

There can be challenges in creating a better relationship with the board. Representatives of administration tend not to like discussing shortcomings in any area with their board, Klein notes.

"Quality issues that have arisen are particularly embarrassing to discuss. This is especially true when there has been an unexpected death or injury," Klein says. "I can remember working tirelessly to educate a board on quality oversight, and the real tipping point came when someone known to the board chair died as a result of a medical error at the hospital. The president of the hospital noted it was truly an unfortunate situation. The board chair corrected him and said it's not just unfortunate, it's actually tragic."

Klein says that point was the moment the hospital president decided he needed more resources for quality and that he probably needed to affiliate with a bigger system to achieve the transformation required to keep pace.

Transparency Is Key

Ideally, the board should be briefed on publicly available hospital comparison websites, Klein says. Patient stories can and should be shared.

Transparency will be key, Klein says. The best approach is to reveal to the board any serious quality issue that has arisen. The incident must be investigated and assessed quickly, with a corrective plan offered, she says.

"It's impossible to assure that there will never be a quality issue to be reported to the board. The trick is to have a plan in place immediately that puts the board at ease," Klein says. "The board must be educated to be comfortable that quality requires continuous transformation and improvement in systems and methods. It should not be static."

Emphasize to board members that they are caregivers just like physicians and nurses, says **Jim Merlino**, MD, president and chief medical officer of Press Ganey's strategic consulting division. He has served on a hospital board. It is important to educate them on what their responsibility is and how it connects to the front lines for patients and caregivers, he says.

"I worry that some board members don't really know what happens on the front line. They need to understand how the decisions the board makes affect individual patients, which requires quality leaders to bring stories to the board, rather than just metrics, to make it real," Merlino says. "Make it personal. A preventable death was not just a nameless statistic; it was a real person who was harmed. A family and the caregivers were affected."

A recent Press Ganey report notes that boards have the ultimate responsibility for the hospital or health system's culture, which comes in large part from the CEO they choose to

Boards Moving From Financial Focus to Include Quality Concerns

The current increased focus on quality and the willingness of hospital boards to back quality initiatives are results of a long progression from a darker era in U.S. healthcare, says a board member who has seen the before and after.

Quality professionals should work to ensure the momentum continues and not let boards slide back into the complacency of yesteryear, says **Tracey Klein**, JD, shareholder with the Polsinelli law and consulting firm in Chicago.

The *To Err Is Human* report from the Institute of Medicine (IOM; now called the National Academy of Medicine) in 1999 spurred greater interest in quality improvement and alerted some hospital and health system boards that they should be more involved in quality issues, she says.

The IOM report kicked off the patient safety and quality movement in U.S. healthcare, with its premise that most errors are systemic in nature and are not solvable at the level of the individual provider. In 2001, a subsequent IOM report, *Crossing the Quality Chasm*, drew further attention to quality improvement, and that was when Klein became heavily involved in the issue, serving on a board as legal counsel and speaking to many others about incorporating quality issues more effectively.

"Prior to that time, most boards concentrated only on financial metrics. Although we have come a long way since the late 1990s, the foundational concepts that really moved the healthcare industry to track and report quality data, as well as review and assess medical errors, really were an outgrowth of those two reports," she says. "It was extremely uncommon for boards of directors to in any way review quality data. Incidents and/or medical errors were not reported up the chain of command, or worse yet were whitewashed."

Many health systems were slow to adopt policies and procedures to assess unexpected deaths or near misses and thereby improve safety and learn from incidents as they occurred, Klein says. Results of such investigations and assessments often did not reach the board level, she says.

"Many of us who had devoted our lives to healthcare were simply horrified by what we saw when we looked in the mirror at that time. Boards were advised to create quality committees and require management to devote resources to routinizing care and monitoring outcomes," she says. "Boards were advised to listen to the stores of injured patients and to receive sentinel event reports

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run the organization. Press Ganey data demonstrate that organizations with higher employee engagement perform better on quality metrics, Merlino notes.

For that reason, quality professionals should address organizational culture with the board, focusing on issues such as turnover rates and employee engagement, he says. *(See the sidebar on page 29 for more on the Press Ganey report.)*

Engaged Board Improves Outcomes

It is crucial for the board to be involved with quality and safety activities, says **Tejal K. Gandhi**, MD, MPH, CPPS, chief clinical and safety officer with the Institute for Healthcare Improvement (IHI) in Boston. IHI recently published a report, "What Boards Must Do to Achieve Better Quality Health Care," that provides guidance on integrating boards into quality efforts. *(See the sidebar on the right for more on that report and other resources.)*

Some research shows a correlation between a more engaged board and better outcomes on the quality and safety front, Gandhi says, but that can come only when the board has a deep understanding of the relevant issues.

"It is important to get commitment from the CEO and board, but also we have to make sure they understand some of the core concepts around quality and safety. That can be a barrier for some of the lay board members who understand finance and similar issues far better than they understand quality and safety," Gandhi says. "Boards need to acquire that core content knowledge so that they can ask the right questions and have much deeper understanding of quality and safety efforts at their organization."

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directly. Board members were recruited who understood the implementation of quality or safety systems in healthcare or other industries."

Peer review of physicians was amped up, with reports to the board or a committee, Klein notes. There was more focus on ensuring that practitioners actually had current clinical competence, and effort put behind monitoring physician performance.

Reimbursement principles also changed to emphasize that providing the right care at the right time reduced costs and enhanced outcomes, Klein notes.

"In short, a lot of good work was accomplished to transform healthcare to make it safer and better. Transformation was time-consuming and expensive," Klein says. "Many standalone hospitals and small systems merged with bigger institutions. Often part of the justification was the small systems could not transform fast enough to keep pace in the quality arena." ■

IHI Offers Resources on Integrating Quality Into Hospital Boards

The Institute for Healthcare Improvement (IHI) in Boston offers several resources to help quality improvement professionals cultivate better working relationships with hospital and health system boards.

Assessing the board's knowledge level and comfort with quality issues is an important first step, says **Tejal K. Gandhi**, MD, MPH, CPPS, chief clinical and safety officer with the Institute for Healthcare Improvement (IHI) in Boston.

IHI offers the Governance of Quality Assessment Online Tool to assist with that step, available online at: https://bit.ly/2G05gBc.

IHI also offers the Framework for Effective Board Governance of Health System Quality, available online at: https://bit.ly/2CWo68b.

Two IHI blog posts also offer advice. "What Boards Must Do to Achieve Better Quality Health" is available online at: https://bit.ly/2G9KYUZ. "The Risks of Keeping Health Care Boards in the Dark" is available online at: https://bit.ly/2WvAS6y. ■

Often Finance-Oriented

Don't be surprised if some boards resist more involvement with quality or at least are unenthusiastic about it. Traditionally, boards have found it easier to talk about financial margins or what the next building might look like, says **Beth Daley Ullem**, faculty lead with IHI and president of Quality and Safety First, a consulting company in Boston. Ullem has served on two boards, sitting on the quality committee for both.

Boards must be shown that quality and safety are the core of what the

organization provides, and therefore it should be a fundamental concern for the board, Ullem says.

Ullem notes that some hospitals require board member immersion in quality. Cincinnati Children's Hospital in Ohio, for instance, expects every board member to serve on the quality committee before any others, she notes.

"Quality is their core operation, so this would be their entryway to understanding the health system," Ullem says. "Doing things like that and taking board members out to see the quality operations in practice are great ways to help your board understand the quality focus. It also shows your commitment to quality upfront rather than having it be just a report or consent agenda in the board meeting."

Even when board members are fully supportive, they often are unsure about exactly what they should be doing in their quality committees or in other oversight of quality and safety issues, Ullem says. They will welcome specific suggestions and roadmaps to follow, she says. "They're looking for something similar to what they would receive if they were in a board or trustee position in the private sector, where each of their committees would receive specific direction on what to oversee."

Don't Discourage Accountability

Be careful not to discourage executive involvement with quality efforts, says **David Munch**, MD, senior principal at Vizient, a healthcare performance improvement company based in Irving, TX.

If executives are held accountable to the board for reporting quality issues, they will be motivated to support and participate in quality improvement efforts, he notes. But if the quality department develops such a direct relationship with the board that those executives are no longer on the firing line, their support and involvement can wane, Munch cautions.

"When the quality department does all the reporting and presentations, it allows the executives to check out, to not think so much about quality in the hospital. Someone else is presenting the data to the board, for better or worse," he says. "That doesn't mean the quality professional shouldn't be at the board meeting to assist or provide resources, but avoid that unintended consequence of taking the executive out of the process and removing their accountability."

Agenda Time Important

A barrier can arise when quality improvement professionals try to get time on the board agenda to make

Board Focuses on Horizon, QI Watches for Icebergs

Quality professionals should help board members understand the overall quality goals of the organization and not necessarily get too bogged down in the minutia, according to a Press Ganey white paper on the hospital board's role in quality improvement.

The report identifies 10 metrics to help boards focus strategies on advancing quality and improving the patient experience.

"The Board needs to have its eyes on the horizon because the senior team often has to focus on the icebergs in the water nearby," according to one executive quoted in the report.

The paper, "A Proposed Quality Report Card for Boards," recommends providing board members a list of 10 critical quality metrics. The recommended Board Quality Report Card includes specific metrics in the areas of safety, communication, teamwork, loyalty, and outcomes. *(The report is available online at: https://bit.ly/2sremiw.)*

The 10 metrics were developed from interviews with CEOs and senior leaders, along with Press Ganey data. The report explains that the metrics provide insight into whether the organization lags its competitors in important dimensions of quality and whether it is improving relative to the needs of patients.

"Boards should be wary of rhetoric that suggests their organization is 'The Best,'" the report says. "Instead, boards should push the perspective of 'No matter how good we may be, our duty and our strategy is to try to get better.' Quality report cards cannot focus purely on process measures (e.g., rate of performance of mammography), which reflect provider reliability in delivering evidence-based medicine, but not meeting patients' needs. Process measures are important but should generally be used internally by management." ■

these inroads, says Gandhi. The CEO often manages the board agenda and keeps a tight grip on allocating time to the many parties who want face time with the board, she notes.

"Some CEOs don't necessarily want board interference in these issues, so we sometimes have to change the CEO's mindset to see how this can be an asset before we ever get a chance to start influencing the board," Gandhi says.

Ullem notes that the notion of quality improvement will not be entirely new to many board members who come from a manufacturing or business background that values quality, culture, workplace safety, and related issues.

The key can be talking to board members in a language they can relate to, which often means minimizing medical jargon. Avoid flooding board members with lots of details and terminology that would be welcomed by a roomful of quality professionals but might be counterproductive with a board.

"While we often pepper the board with terms and issues specific to healthcare, the fundamental concepts are operational things that the board can understand from their own industries. If we take out some of the medical acronyms, we can create a bridge for us being able to speak the same language," Ullem says. "They may not understand what a pressure ulcer is, but they certainly know how to read a run chart and understand defect rates. They can understand when you talk about managing a process for decreasing what is effectively a defect in our care, because if you manage a manufacturing plant, that is what you deal with all the time."

Tips for Better Board Engagement Include Transparency, Brevity

The best relationships with hospital boards come from building trust and keeping them informed, say those who work closely with board members.

Demonstrate you are a partner in supporting their governance role by providing context to help them better understand the information and metrics, says **Diane Rafferty**, managing director with Healthcare Industry Group at the consulting firm Alvarez & Marsal in Los Angeles.

The benefits of a better relationship between quality professionals and the hospital board are immeasurable, says **Kathleen Murphy**, managing director with Healthcare Industry Group at Alvarez & Marsal in New York City.

Consider these tips for ensuring the best board impact on quality improvement:

- When you have a chance to influence the selection of board members, consider candidates with clinical backgrounds, Rafferty says.
- Determine the right amount of information required for the board to govern vs. manage, Murphy recommends.
- Be cautious of board members overreacting to information, and help them understand it in context, Rafferty says. Provide trended data compared to national benchmarks and any quality metrics that impact reimbursement. Do not just give them a snapshot. Help them understand the long view.
- Provide detailed accounts of adverse safety events, Murphy advises. Real-life examples will resonate with them and help them understand. Help them to make a correlation between these situations and the seriousness of their board oversight. Explain the root cause of these types of safety events and the specific action plan that has been implemented to prevent it.
- Encourage questions and feedback. The board should be asking questions about how the organization identifies, investigates, addresses/resolves, and prevents, Rafferty says.
- Tell the truth — the good, the bad, and the ugly, Murphy says. Do not sugar coat. Do not cover up.
- Remind board members that "We are all in this together." The board is held accountable for governance when adverse events occur, Rafferty notes.
- Update your quality dashboard regularly. Make sure the data are real-time, trended, and meaningful, changing in response to adverse events and trends, Murphy says.

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Play to Business Experience

Similarly, it is useful to encourage board members to think in terms of patient expectations. This is a concept they can relate to in the business world, Ullem says.

"CEOs in the business world think about delivering on consumer expectations, whether that is good pricing, good customer experience, an airline getting you there on time and not losing your bags. They understand this concept," she says. "So, we can work to have them think about customer expectations in healthcare and the board members' role in overseeing that. If you mention STEEEP, their eyes will glaze over, but you can talk instead about how the patient expects us to keep them safe and expects us to help them navigate their care."

Cullen says the business background of board members may even make them useful allies when quality professionals need more support from hospital management.

"The board can inject a perspective that the medical community and hospital management are now always on board with. They can say the patient experience is a major quality dynamic for us, a competitive dynamic for us, and you need to be looking at patients as customers rather than as a captive audience that we can do things to," Cullen says.

Boards also will be drawn to the importance of the patient experience in setting the hospital apart from competitors, Turgon notes.

Especially in competitive markets, new payment models are forcing hospitals to become more patient-centered, and board members will see the value in quality improvement efforts.

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• Provide five- to 10-minute presentations on a quality concept at board meetings to further their education on concepts that might be unfamiliar, suggests **David Munch**, MD, senior principal at Vizient, a healthcare performance improvement company based in Irving, TX. This can be especially helpful for board members who come from a business background unrelated to medicine and for community members who serve on the board. One idea is to assign an article to be read before the meeting and then discuss it with board members, he says.

• Invite board members to round on the floors, Munch says. In addition to learning more about quality concerns, board members tend to be more emotionally engaged once they see how these issues directly affect actual patients and staff, he says.

• Make site visits to another hospital. Munch suggests taking the board to another facility to meet with its board and see how they incorporate quality issues into their work. Seeing how another organization does well with this goal can be powerful, he says.

• Manage the amount of data presented to the board. Avoid overloading the board with huge volumes of data each month, Munch suggests. Instead, break it down so that you rotate each month through data on a particular area and then move to a different area the next month, he says. ■

SOURCES

- **Kathleen Murphy**, Managing Director, Healthcare Industry Group, Alvarez & Marsal, New York City. Phone: (212) 328 8605. Email: kmurphy@alvarezandmarsal.com.
- **Diane Rafferty**, Managing Director, Healthcare Industry Group, Alvarez & Marsal, Los Angeles. Phone: (949) 939-4190. Email: drafferty@alvarezandmarsal.com.

"If they don't have that proactive approach to communicating where you are in quality, you're at the mercy of Yelp or Healthgrades, and that does not always tell the story," Turgon says. "It often does not necessarily tell the story the board wants to be told." ■

SOURCES

- **Scott J. Cullen**, MD, Principal, ECG Management Consultants, Boston. Email: sjcullen@ecgmc.com.
- **Tejal K. Gandhi**, MD, MPH, CPPS, Chief Clinical and Safety Officer, Institute for Healthcare Improvement, Boston. Phone: (617-301-4800.
- **Tracey Klein**, JD, Shareholder, Polsinelli, Chicago. Phone: (312) 873-3613. Email: tklein@polsinelli.com.
- **Jim Merlino**, President and Chief Medical Officer, Press Ganey, South Bend, IN. Phone: (800) 232-8032.
- **David Munch**, MD, Senior Principal, Vizient, Irving, TX. Phone: (615) 206-0701.
- **Jessica Turgon**, Principal, ECG Management Consultants, Arlington, VA. Phone: (571-257-1017. Email: jturgon@ecgmc.com.
- **Beth Daley Ullem**, Faculty Lead, Institute for Healthcare Improvement, Boston. Phone: (617-301-4800.

Quick Wins Bring Improvement for Little Money or Time

Some of the most satisfying quality improvement efforts are the "quick wins" in which you make a meaningful contribution to patient care without having to invest a great deal of time, effort, or money.

Anne Arundel Medical Center in Annapolis, MD, has seen success with a number of quick wins that leaders there say could be implemented at other facilities or inspire other quality professionals to find their own small but meaningful changes.

One quick win involved the bedside drinking water containers at the facility, notes Chief Nursing Officer **Barbara Jacobs**, MSN, RN. The hospital had been using the standard plastic pitchers found in many facilities. When you're 80 and not well, it's hard to hold on to that pitcher and pour water into a cup, she explains.

The hospital switched to large see-through plastic cups with a handle and a straw, which were much easier for patients to use.

"We increased our oral intake for patients by 60%. That has had a profound difference in maintaining the hydration of older patients," Jacobs says. "Keeping patients hydrated reduces the chances of delirium, which in turn reduces other risks."

The cups have measurements on the side so that the patient, family, and nurse can see how much has been consumed, explains **Lil Banchero**, RN, senior director of the Institute for Healthy Aging at Anne Arundel Medical Center. Nurses and family can more effectively monitor and encourage the patient to hydrate because the water can level can be seen at a glance.

The new cups also reduce spillage, which is important for maintaining the dignity of the patient, Banchero says. They cost a little more than the standard plastic pitcher.

Mobility Techs Expand Role

Anne Arundel also improved mobility for elderly patients by rearranging expectations for technicians who assist with moving patients. Without increasing full-time equivalents, the hospital redesigned roles for those technicians, with one "mobility tech" being reclassified as a "quality tech." This was part of educating the staff about the importance of mobility and setting higher expectations for the amount of mobility.

"It used to be that as a nurse, you felt good about getting the patient out of the bed and into a chair. Or they might walk three feet," Jacobs says. "We've completely changed the expectations so that we're getting them on their feet and moving in a productive way. Simply pivoting into a chair is not enough."

The mobility techs now take patients for a group lunch, improving both their mobility and their social interaction, Jacobs says. This counters the common threat of social isolation for older patients and results in improved cognition, she says.

"We have family members saying their dad seems more alert and actually wants to get out of bed and go to lunch," Banchero says. "That was a quick win with no added resources. We had one patient who was readmitted and was upset when she wasn't immediately taken to lunch with the others."

The increased mobility also allows physical therapists to concentrate on those who need the most attention to become ambulatory, since nurses don't have to wait on physical therapy to ambulate every patient, Banchero says. The better mobility also improves the hospital's length-of-stay metrics.

"We found that sometimes we would have patients who were still in the hospital only because the doctor wrote an order for physical therapy, when they actually didn't need a physical therapist to get them up and walking," Jacobs says.

What Matters Most

Anne Arundel also had quick success with emphasizing what matters most to the patients and having that drive care decisions. Hospital leaders felt strongly that patient care should be oriented toward what matters most to the patient, and that can be quite different among individuals, Jacobs says.

For some patients, what matters most might be their grandchildren. Others might say their pets at home. Still others might say music or a goal like walking again.

Whatever it is, the hospital puts it on a whiteboard in the patient's room, showing everyone "what matters most." The hospital provided T-shirts with that slogan to the staff and encouraged employees to talk to patients about what matters most to them.

"Anyone who walks in can see the whiteboard and strike up a conversation and ask about the grandkids or what kind of music the patient loves," Jacobs says. "We

want to know that we're touching what matters to this patient, helping them focus on that and get better so they can enjoy that, rather than us deciding what should matter to them."

Letting Patients Sleep

One offshoot of that effort was the realization that expectant mothers consistently used the phrase "healthy baby" as what mattered most to them. The hospital picked up on that and purposefully uses that phrase often in discussing maternal care, Jacobs says.

Similar revelations came in other units where patients had consistent focus on a particular issue like pain relief or going home, Banchero says. That information also was used to direct patient care and how staff members interact with patients.

Anne Arundel also moved away from routinely collecting vital signs during the night so that patients' sleep was not disturbed unless necessary.

"Sometimes those checks are necessary, but a lot of times, there is no justification for waking a patient up at 2 a.m. to check their blood pressure. You're doing more harm than good by disturbing their sleep, so we worked with our medical guidelines and adjusted our electronic record so it doesn't automatically prompt for those checks during the night," Jacobs says. "That was an easy win, something that made sense to everyone and could be done very easily." ■

SOURCES

- **Lil Banchero**, RN, Senior Director, Institute for Healthy Aging, Anne Arundel Medical Center, Annapolis, MD. Phone: (443) 481-1000.
- **Barbara Jacobs**, MSN, RN, Chief Nursing Officer, Anne Arundel Medical Center, Annapolis, MD. Phone: (443) 481-1000.

Focus on Women and Children Brings Certification, Recognition

St. Joseph Medical Center in Tacoma, WA, recently was certified as a Baby-Friendly hospital, which is a World Health Organization and United Nations Children's Fund initiative designed to encourage breastfeeding. Leaders there say the achievements that led to the certification could be duplicated at other hospitals seeking to improve maternal quality of care.

However, they point out that the certification does not come easily.

The Baby-Friendly designation process was challenging because it required St. Joseph to revamp the way it works with expectant mothers and staff to educate them about breastfeeding, says **Michelle H. Kinne**, IBCLC, ICCE, CD(DONA), international board-certified lactation consultant and lead for the Baby-Friendly Hospital Initiative Project at St. Joseph.

Now, all of the other hospitals under the CHI Franciscan umbrella are following suit. The Baby-Friendly Hospital Initiative (BFHI) is a global initiative of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). The goal is to improve health outcomes for pregnant women, mothers, and newborns through breast-feeding. *(More information is available online at: https://bit.ly/1KcIemg.)*

Hospitals seeking the certification must meet the criteria established by the BFHI, which includes 10 steps and additional requirements to encourage breast-feeding and best practices when mothers cannot breast-feed. *(See the sidebar on page 34 for an example of the requirements.)*

No Easy Task

To comply with the rigorous BFHI review process, St. Joseph nurses and medical staff took part in 20 hours of required education. The hospital also made changes to its breast-feeding policy.

St. Joseph used grant funding from the United Way to set up an interdisciplinary committee with nurses, physicians, lactation consultants, leadership, and ancillary staff, Kinne says. The committee worked to develop an action plan to collect data, develop new breast-feeding policies, train staff and physicians, and publish breast-feeding educational materials for patients.

Adhering to the BFHI guidelines required significant changes to existing policy and procedures, says **Jakki Stodola**, MBA, BSN, RNC, director of the family birth center at St. Joseph. The certification requires far more than simply telling parents that breast-feeding is the best option, she notes.

"It was quite a laborious quality project. It was far-reaching, beyond our own department," Stodola says.

"We were trying to convince people to do things that they really didn't think they needed to do. That was one of the biggest challenges."

The effort was worthwhile, Stodola says, and staff are proud to have achieved the certification. St. Joseph changed the culture surrounding breast-feeding, she says.

The primary practice changes took place in the hospitals' birth centers and neonatal ICUs, but the project requires the involvement of many other parts of the hospital infrastructure, Kinne explains. It intersects with procurement and contracting, outpatient ambulatory care services, and the supply chain.

"The challenge is balancing the desire for quality improvement while being held to various standards for productivity and budget," Kinne says. "How do you balance funding the work that is necessary to accomplish the goals associated with your project while you're being held responsible for other expectations as well? The project required a change in mindset for some of our team, and that takes education, time, and modeling."

Significant Commitment of Time, Money

Every nurse in the department was assigned 15 hours of didactic education, plus five hours of hands-on learning with certified lactation consultants, notes **Debbie Raniero**, RNC, regional director of women's and children's services with CHI Franciscan, the parent company of St. Joseph in Tacoma, WA.

"With almost 200 nurses, it was a significant financial and time commitment for the organization," Raniero says. "We feel lucky that our senior leadership recognized the importance of this and supported the project."

Kinne found that networking with

Breast-feeding as Standard Practice

The Baby-Friendly Hospital Initiative (BFHI) is premised on the idea that quality healthcare requires actively promoting breast-feeding.

"Breast-feeding has been recognized by scientific authorities as the optimal method of infant feeding and should be promoted as the norm within all maternal and child healthcare facilities," according to the principles on which BFHI creates criteria for certification. "The most sound and effective procedural approaches to supporting breast-feeding and human lactation in the birthing environment that have been documented in the scientific literature to date should be followed by the health facility."

BFHI provides extensive criteria for certification. An example is the first guideline for healthcare facilities:

"GUIDELINE: Breast-milk should be the standard for infant feeding. All infants in the facility should be considered to be breast-feeding infants unless, after giving birth and being offered help to breast-feed, the mother has specifically stated that she has no plans to breast-feed (see steps 4 and 5). The facility should have a written policy (Step 1) that addresses the implementation of Steps 2-10 as well as the International Code of Marketing of Breast-Milk Substitutes, and communicates the Baby-Friendly philosophy that mothers room with, care for, and feed their own well infants and should be protected from the promotion of breast-milk substitutes and other efforts that undermine an informed feeding choice. All areas of the facility that potentially interact with childbearing women and babies will have language in their policies about the promotion, protection, and support of breast-feeding. Policies of all departments will support and will not countermand the facility's breast-feeding policy and be based on recent and reliable scientific evidence."

BFHI lists these criteria for evaluating compliance with that guideline.

- "The facility will have written maternity care and infant feeding policies that address all Ten Steps, protect breast-feeding, and adhere to the International Code of Marketing of Breast-Milk Substitutes.
- All areas of the facility that potentially interact with childbearing women and babies will have language in their policies about the promotion, protection, and support of breast-feeding.
- Policies of all departments will not countermand the facility's breast-feeding policy.
- Review of all clinical protocols, standards, and educational materials related to breast-feeding and infant feeding used by the maternity services indicates that they are in line with BFHI standards and current evidence-based guidelines.
- The Nursing Director/Manager will be able to identify the healthcare professionals who have ultimate responsibility for assuring the implementation of the breast-feeding policy." ■

her counterparts at other hospitals was helpful in moving the project forward, particularly with mining details that were not readily apparent in the criteria provided by BFHI.

She notes that while BFHI is a global program, each country has its own certification body, and the standards can be different from one to another.

"We have to be mindful not to take criteria from another country because it may not necessarily translate into what you're expected to do in the United States," she says. "I would recommend reaching out to other hospitals pursuing this certification, or those that have achieved it already, to learn about the realities of putting these guidelines into practice. Meet with them and learn about their successes and their challenges, too, so you can apply that knowledge in your own effort." ■

SOURCES

- Michelle H. Kinne, IBCLC, ICCE, CD(DONA), International Board Certified Lactation Consultant and Baby-Friendly Hospital Initiative Project Lead, Tacoma, WA. Phone: (253) 382-8576. Email: michellekinne@chifranciscan.org.
- Debbie Raniero, RNC, Regional Director of Women's & Children's Services, CHI Franciscan, Tacoma, WA. Phone: (253) 382-8586. Email: debbieraniero@chifranciscan.org.
- Jakki Stodola, BSN, RNC, Director, Family Birth Center, St. Joseph Medical Center, Tacoma, WA. Phone: (253) 426-6752. Email: jakkistodola@chifranciscan.org.

Optima Health Applies SDOH With Nutrition Programs, Mobile Healthcare

Social determinants of health (SDOH) continue to influence quality improvement efforts across the healthcare system, with a Virginia health plan and health system using the data to improve nutrition and even provide mobile vans to take services into the community.

SDOH data can be obtained through vendors and also through the health system's own experience with patients, explains **Thomas Lundquist**, MD, MMM, FAAP, FACPE, senior vice president and chief medical officer with Optima Health, a health plan in Virginia Beach, VA, that is part of the Sentara health system.

"Both the health plan and the health system are increasingly capturing social determinants of health, and one of the things I look at is whether we should buy that data broken down by ZIP code or whether we should capture that information directly as our health system and health plan professionals interact directly with patients and families," he says.

"The answer is that it should be a hybrid eventually because if we enter a new market, we can purchase access to a database that will show us what to expect on a ZIP-code level and maybe even by street. And once we're in there a while, we develop our own data as we interact with them and determine what needs and limitations they have."

One initiative that used SDOH within the Sentara health system is providing mothers with easy access to federally funded support programs, Lundquist notes. The traditional enrollment process for the federal supplemental nutrition program for Women, Infants, and Children (WIC) requires mailing the request for assistance, but in an effort to eliminate any potential travel barriers and also to expedite the request for assistance, a Sentara hospital employee facilitates the sign-up process at the new mother's bedside.

"We find ourselves increasingly prescriptive when it comes to traditional social services outreach, encouraging members to enroll in WIC and to allow us to facilitate assistance with their utilities and housing," Lundquist says. "We can only do that when we have that social determinants of health data. That requires us to have a care management system and an electronic record that captures that data and allows us to dive more deeply into details such as whether you live in a one-story or two-story home, whether you have carpet on your stairs."

In addition, Optima Health executed a program that provides new mothers with healthy meals following discharge from the hospital through a partnership with local food banks. It currently serves approximately 50 mothers per month with two meals a day for 90 days postpartum.

Optima Health also has worked closely with Sentara to proactively involve and engage community members, Lundquist says. Optima Family Care and Optima Health Community Care, both Medicaid programs for those with low income and disabilities in Virginia, implemented a statewide initiative called the Health Education and Awareness Program to encourage healthy living and lifestyles among youth.

Lundquist notes that lack of access to transportation also has been determined to be a barrier in receiving healthcare.

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Optima Health partnered with organizations such as The Health Wagon in rural Appalachia, which provides mobile health vehicles for medically underserved communities in Virginia to deliver essential, free health services, such as mammograms and flu shots.

It has been an effective means of providing compassionate, quality care to rural communities with limited access to services, Lundquist says.

"The biggest challenges are prioritization, how to reach the services people need, and deciding what should be under our purview to pay for versus just connecting people to community resources and hoping for the best," Lundquist says. "We're evolving our systems to better capture the social determinants of health data … so that the nurse working with the patient can connect the dots in the moment and put things in motion more efficiently." ■

SOURCE

- **Thomas Lundquist**, MD, MMM, FAAP, FACPE, Senior Vice President and Chief Medical Officer, Optima Health, Virginia Beach, VA. Phone: (757) 552-7401.

CE QUESTIONS

1. **What does Tracey Klein, JD, say is one key to working effectively with the hospital board?**
   a. Transparency
   b. Avoiding news that may be discouraging
   c. Preventing board members from taking control of quality efforts
   d. Making sure all information flows through the CEO to the board

2. **What does David Munch, MD, say is the risk from having only the quality director present information to the board?**
   a. The board will not fully understand the data.
   b. The other leaders may become disengaged from quality efforts if they are not held accountable by the board.
   c. Board members will not consider the presentation significant.
   d. The other leaders may resent the attention given to the quality director.

3. **How did Anne Arundel Medical Center in Annapolis, MD, improve patient hydration by 60%?**
   a. Changed bedside water pitchers to see-through cups with straws
   b. Started providing bedside water pitchers for all patients
   c. Provided flavored water upon patient request
   d. Posted hydration goals in each patient room

4. **When St. Joseph Medical Center in Tacoma, WA, sought certification for breast-feeding, what was the total amount of new training required for nurses?**
   a. 5 hours
   b. 10 hours
   c. 20 hours
   d. 30 hours

CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general.
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.